

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 06135 195

## 1. PLACE OF DEATH:

County Howard Co.  
 City or town 1792 Ridge View Laurel  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Oliver Wandy

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary A. Wandy

7. Birth date of deceased (mo., day, yr.) Jan 3, 1891  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 54 Months 6 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)

10. Usual occupation Machinist11. Industry or business Machin Shop12. Name Joe A. Wandy13. Birthplace Md.14. Maiden name Ellen R. Craig15. Birthplace Baltimore, Md.16. Informant Mary A. WandyAddress Laurel, Md.

17. Burial Date thereof June 10, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CommonwealthLocation Scaggsville, Md.18. Funeral director W. H. Smith & SonAddress Laurel, Md.6/9/45. Shirley Shipley

19. (Date rec'd by registrar) 13. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town Laurel - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Laurel-Highland Rd.

(If rural, give LOCATION)

2. (c) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

218-07-2646

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 8 1945 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 8 1945 to 6 8 1945and that I last saw him alive on 6 8 1945Immediate cause of death acute coronary thrombosis

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. BrownAddress Laurel, Md.Date signed 6-9-45

RECEIVED  
JUN 12 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4821

## CERTIFICATE OF DEATH

★  
Reg. Dist. No.06141  
195

## 1. PLACE OF DEATH:

County Howard  
 City or town Samuel (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 yrs  
 Hospital, institution or street address where death occurred:  
High - Ridge  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard  
 City or town Samuel (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME,

Midahy Cecilia Smith

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Raymond S. Smith

7. Birth date of deceased (mo., day, yr.)

5. (c) If alive, give age \_\_\_\_\_ years

Aug 21 - 1881

8. AGE:

Years

Months

Days

If less than one day

63938

hrs.

min.

9. Birthplace

Wheaton, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

House

FATHER

12. Name

Epiphany Thomas

13. Birthplace

Md.

MOTHER

14. Maiden name

Ellen Jane ?

15. Birthplace

Md.

16. Informant

Raymond S. Smith

Address

Samuel, Md.

17.

(Burial, cremation, or removal) Which?

Date thereof

June 23, 1945  
(month) (day) (year)

Cemetery or crematorium

Location

Samuel, Md.

18. Funeral director

Address

Samuel, Md.

19.

(Date rec'd by registrar)

6/21/45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 19

19

45 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8215x

to

61945

and that I last saw him alive on

61945

Immediate cause of death

acute cardiacdilatation

Due to

7. Sp. Metastasis

Due to

Primary (Cervix)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Hysterectomy

Autopsy results

Rt. nephrectomy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. P. Warren

M. D. or other

Address

Samuel, Md.

Date signed

6/21/45

RECEIVED  
JUN 23 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (472)

## CERTIFICATE OF DEATH

06136

Reg. Dist. No. 192

## 1. PLACE OF DEATH:

County... Howard

City or town... Mayfield  
(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Howard

City or town... Mayfield  
(If outside city or town limits, write RURAL and give nearest town)Street No... Independence Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Walter Gilbert

## 3. (b) Social Security Number

4. Sex... m 5. Color or race... w 6. (a) Single, married, widowed, or divorced... married

6. (b) Name of husband or wife... Lena Gilbert

7. Birth date of deceased (mo., day, yr.)... June 12, 1903 6. (c) If alive, give age... years

8. AGE: Years... 42 0 17 Months... Days... If less than one day... hrs. min.

9. Birthplace... Md.  
(Town, county, and state)

10. Usual occupation... Cemetery Worker

11. Industry or business... Random Park

12. Name... Walter Gilbert

13. Birthplace... Md.

14. Maiden name... Augusta Blutz

15. Birthplace... Md.

16. Informant... Mrs. Walter Gilbert

Address... Elliott City Md

17. Burial (Burial, cremation, or removal. Which?)... Burial Date thereof... 7-7-1945  
(month) (day) (year)

Cemetery or crematory... Random Park

Location... Burdette Md

18. Funeral director... H. H. Nigamathom

Address... Elliott City Md

19. 7-7-1945 Alice W. Hubbs  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 29, 1945, at 10:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to June 29, 1945 and that I last saw him alive on June 27, 1945.

Immediate cause of death... Coronary of the heart

Due to... lung

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... H. H. Nigamathom M.D.

Address... H. H. Nigamathom M.D. Date signed... 7/9/45

RECEIVED

JUL 9 1945

BUREAU V.S.

1945  
82  
86



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

## CERTIFICATE OF DEATH

06137

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Howard  
 City or town Lysbournville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard  
 City or town Lysbournville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert J. Hamilton

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

Widowed

## 6.(b) Name of husband or wife

Ida M.

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 27, 1875

## 6.(c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

6972

hrs.

min.

## 9. Birthplace

Md.

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## FATHER

## 12. Name

George Hamilton

## 13. Birthplace

Md.

## MOTHER

## 14. Maiden name

Margaret Ann Keller

## 15. Birthplace

Md.

## 16. Informant

Mrs. Edna Heathill

## Address

5327 Hamlin Ave. Balt. Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

7-1-45

## Cemetery or crematory

Union Chapel Cw.

## Location

Liberty Park, Md.

## 18. Funeral director

Chas. Harry Weer

## Address

Lysbournville, Md.

## 19.

(Date rec'd by registrar)

19

45Chas. Harry Weer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 1:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1935

19

to

death

19

and that I last saw him alive on June 29, 1945 19

## Immediate cause of death

chronic myocarditis  
chronic arteriosclerosis  
senility

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Lawson, M.D.

M. D. or other

Address

Lysbournville

Date signed

6/29/45

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REL IV  
JUL 9 1945  
BUREAU V.S.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06138

Reg. Dist. No.

190

## 1. PLACE OF DEATH:

County HowardCity or town Dorsey, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Dorsey, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Dorsey Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frank Lottman

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

B. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

None

7. Birth date of

deceased (mo., day, yr.)

Feb. 22, 1890

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

55328

..... hrs.

..... min.

9. Birthplace

Illinois

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Derk Lottman

13. Birthplace

Germany

MOTHER

14. Maiden name

Sarah Warlock

15. Birthplace

Illinois

16. Informant

Derk Lottman

Address

Elbridge, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 22, 1945  
(month) (day) (year)

Cemetery or crematory

Trinity

Location

Dorsey, Md.

18. Funeral director

Easton Sons

Address

Elliott City, Md.

19.

(Date rec'd by registrar)

19

45

(Miss)

Ellie

Registrar

Address

28. SIGNATURE

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

M. D. or other

Address

George E. Burdette, Jr.  
Elliott City, Md.

Date signed

6/19/45

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 19 45, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/19 19 45, to 6/19 19 45and that I last saw him alive on no date 19 45

Immediate cause of death

Coronary occlusion

DURATION

Instant

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

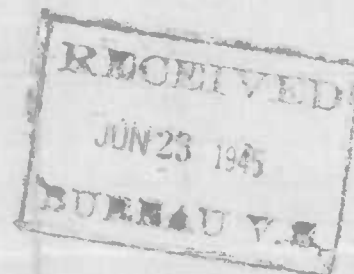
(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-P)

## CERTIFICATE OF DEATH

06139

Reg. Dist. No. 195

1. PLACE OF DEATH: **HOWARD**  
County.....  
City or town..... **SAVAGE**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **55 YRS.**  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... **MD.** County..... **HOWARD**  
City or town..... **SAVAGE**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
**JAMES ALVIN MEWSHAW**

3. (b) Social Security Number  
**213-01-7740**

4. Sex..... **M** 5. Color or race..... **W** 6.(a) Single, married, widowed, or divorced..... **MARRIED**  
6.(b) Name of husband or wife..... **JESSIE E. MEWSHAW**  
6.(c) If alive, give age..... **59** years  
7. Birth date of deceased (mo., day, yr.)..... **NOV. 2, 1883**  
8. AGE: Years..... **61** Months..... **7** Days..... **12** If less than one day..... hrs. min.

9. Birthplace..... **SAVAGE, MD.**  
(Town, county, and state)  
10. Usual occupation..... **CARPENTER (Textile)**  
11. Industry or business..... **SAVAGE MFG. CO.**  
12. Name..... **EBENEZER S. MEWSHAW**  
13. Birthplace..... **A.A. Co., MD.**  
14. Maiden name..... **MARTHA J. BOUNDS**  
15. Birthplace..... **HOWARD CO., MD.**

16. Informant..... **Harold E. Mewshaw**  
Address..... **Savage, Md.**  
17. Burial..... **Burial** Date thereof..... **June 14, 1943**  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory..... **Savage, Md.**  
Location..... **Savage, Md.**  
18. Funeral director..... **Frank Shipley**  
Address..... **616 145**  
19. (Date rec'd by registrar)..... **6/16/45** Registrar..... **Frank Shipley**

### MEDICAL CERTIFICATION

2D. DATE OF DEATH..... **June 14** 19. **45** at **10<sup>20</sup> P. M.**  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 43** to **June 14** 19. **45**  
and that I last saw him alive on **June 14** 19. **45**  
Immediate cause of death..... **Cardiac Failure**  
Due to..... **Chn. Myocarditis**  
Due to..... **Coronary Thrombosis**  
Other conditions..... **Chn. Nephritis**  
(Include pregnancy within 3 months of death)

### DURATION

**1 mo.**  
**2 yrs.**  
**8 yrs.**  
**5 yrs.**

Major findings of operations.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?

23. SIGNATURE..... **Frank Shipley M.D.**  
Address..... **Savage, Md.** Date signed..... **6/16/45**

MARGIN RESERVED FOR BINDING

1

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED  
JUN 19 1945  
BUREAU V.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

noted 1st. 191

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

06140

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HOWARD  
 City or town FULTON  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

ON ZIMMERMAN FARM.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VA. County BERKLEY

City or town MARTINSBURG  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 669 FRANKLIN AVE  
 (If rural, give LOCATION)

2.(a) If veteran, name war NONE ✓

## 3.(a) FULL NAME

GEORGE W. MILLER.

## 3.(b) Social Security Number

NONE

4. Sex <u>MALE</u>	5. Color or race <u>WHITE</u>	6.(a) Single, married, widowed, or divorced <u>WIDOWED</u>
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6.(b) Name of husband or wife ELIZABETH

7. Birth date of deceased (mo., day, yr.) MAY - 25 - 1868  
 6.(c) If alive, give age ..... years

8. AGE: Years <u>77</u>	Months <u>0</u>	Days <u>8</u>	If less than one day ..... hrs. .... min.
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9. Birthplace WARREN Co., VA.  
 (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

12. Name WILLIAM MILLER13. Birthplace VA.14. Maiden name EMILY CAMERON15. Birthplace VA.16. Informant WILBERT T. MILLERAddress 831 N. LINCOLN AVE, ARLINGTON, VA.

17. BURIAL Date thereof MAY 6 - 1955  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ROCKLANDLocation ROCKLAND - WARREN Co. VA.18. Funeral director James E. HumphreyAddress 803 G AVE - SILVER SPRING - MO

19. .... 19 .....  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3 19 45 at 3 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/3 19 45 to 6/3 19 45  
 and that I last saw him alive on no date 19 .....

Immediate cause of death Coronary Occlusion DURATION Instant

Due to .....

Due to .....

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Bunting MD  
 DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M.D. or other

Address Ellicott City, Md. Date signed 6/3/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

06142

190

## 1. PLACE OF DEATH:

County HowardCity or town and Waterloo  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1425 Mather St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Freddie Richardson

## 3. (b) Social Security Number

## 4. Sex

m

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Viola

## 7. Birth date of deceased (mo., day, yr.)

Aug 22, 1914

## 6. (c) If alive, give age

29 years

## 8. AGE:

Years

Months

Days

If less than one day

30916

hrs.

min.

## 9. Birthplace

Florence S.C.  
(Town, county, and state)

## 10. Usual occupation

Severore

## 11. Industry or business

FATHER

## 12. Name

Jimmy Richardson

## 13. Birthplace

S.C.

## MOTHER

## 14. Maiden name

Carrie Lee

## 15. Birthplace

S.C.

## 16. Informant

Viola Richardson (wife)

## Address

Mather, N.C.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

6/14/45  
(month) (day) (year)

## Cemetery or crematory

Unity Baptist

## Location

Florence S.C.

## 18. Funeral director

Chas. G. Gough

## Address

512 N. Carroll Ave.

## 19.

6/3/45  
(Date rec'd by Registrar)R.D. Helrich  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945 at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/9 1945 to 6/9 1945  
and that I last saw him alive on no date 1945

Immediate cause of death

Communited Skull fracture and visceration

DURATION

Instant

Due to

Due to

Other conditions

multiple fracturesinstant

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/8/45Where did injury occur? Waterloo Howard md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where)? Baltimore Washington Dist.Means of injury struck by auto truck Injured at work? no

23. SIGNATURE

George E. Buntorf M.D.  
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY D. or otherAddress Ellicott City, Md. Date signed 6/9/45

Lex  
0480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age of deceased is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

06143

FILM No. G 96 JUL 11 1945

## CERTIFICATE OF DEATH



Reg. Dist. No. 191

### 1. PLACE OF DEATH:

County Howard  
City or town Pleiffer Corner  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 32 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard  
City or town Pleiffer Corner  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

John Henry Rollins

### 3. (b) Social Security Number

215-12-4195

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widower  
6.(b) Name of husband or wife Ada Wilson Rollins  
7. Birth date of deceased (mo., day, yr.) May August 15, 1873  
6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 71 Months 43 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Howard Co., Md.  
(Town, county, and state)

10. Usual occupation Laborer

### 11. Industry or business

12. Name Andrew Rollins  
13. Birthplace Howard Co., Md.  
14. Maiden name Sophia Rollins  
15. Birthplace Howard Co., Md.

16. Informant Mrs. Sophia Matthews  
Address 4652 Falls Rd. Balto. Md.

17. Burial Date thereof July 1, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Odd Fellows Cemetery  
Location Elkridge, Md.

18. Funeral director Easton Sons  
Address Ellicott City, Md.

19. June 30 19 45 John D. Loughran  
Date rec'd by registrar Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 19 45 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/27 19 45 to 6/27 19 45  
and that I last saw h. 100 alive on no date 19 45

Immediate cause of death Coronary Thrombosis DURATION instant

Due to arteriosclerotic Cardio-Vascular Disease 3 yr.

Due to \_\_\_\_\_

Other conditions none

(Include pregnancy within 3 months of death.)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George E. Bughy  
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other  
Address Ellicott City, Md. Date signed 6/27/45

RECEIVED

JUL 6 1945

BUREAU V.S.